

## ATTACHMENT 1

### CENTER FOR MEDICARE AND MEDICAID SERVICES SPECIAL TERMS AND CONDITIONS

**NUMBER:** 11-W-00004/1

**TITLE:** Rhode Island RItE Care Demonstration

**AWARDEE:** Rhode Island Department of Human Services

#### LEGISLATION

1. The state shall, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that occur after August 1, 1995. To the extent that a change in Federal law, which does not exempt state section 1115 demonstrations, would affect state Medicaid spending in the absence of the waiver, CMS shall incorporate such changes into a modified budget limit for the RItE Care 1115 demonstration. The modified budget limit will be effective upon implementation of the change in Federal law, as specified in law. If the new law cannot be linked specifically with program components that are or are not affected by the RItE Care demonstration (e.g., laws affecting sources of Medicaid funding), the state shall submit its methodology to CMS for complying with the change in law. If the methodology is consistent with Federal law and in accordance with Federal projections of the budgetary effects of the new law in Rhode Island, CMS would approve the methodology. Upon approval of the legislation, CMS and the state will mutually agree to a time frame for developing and submitting a methodology to CMS for complying with the change in law. Should CMS and the state fail to mutually agree to a time frame or if CMS does not accept the state's proposed methodology, a reduction or increase in Federal payments shall be made according to the method applied in non-waiver states.
2. The state may submit to CMS a request for an amendment to the RItE Care program to request exemption from changes in law occurring after August 1, 1995. The cost to the Federal government of such an amendment must be offset to ensure that total projected expenditures under a modified RItE Care 1115 demonstration program do not exceed projected expenditures in the absence of the RItE Care demonstration (assuming full compliance with the change in law).

#### PLAN CONTRACTING

1. All contracts and modifications of existing contracts between the state and managed care organizations (MCOs) must be approved by CMS prior to the effective date of the contract or modification of an existing contract. The state will provide CMS with a minimum of 30 days to review and approve changes.

CMS reserves the right to review individual subcontracts with plans in accordance with the same requirements as those imposed by these Special Terms and Conditions on plans. Copies of subcontracts or individual provider agreements with plans shall be provided to CMS upon request.

2. The state shall provide for ongoing monitoring of managed care plan physician capacity, including both primary care providers and specialists, and must report any significant increases or decreases in capacity, or any other significant changes that may impact capacity, e.g., mergers of managed care plans, to CMS.
3. The state must fully meet the usual Medicaid disclosure requirements at 42 CFR 455, Subpart B, for contracting with managed care organizations.
4. For those plans that do not meet section 1903(m) requirements, prior to award of contracts to these plans, the state shall submit for CMS approval a description of their delivery system, their financial viability, and their quality assurance system.
5. The state will continue to maintain a contract with a health care management consulting firm experienced in Health Plan management, which will be responsible for managing the operational and administrative aspects of the program under the state's direction. The final contract shall be submitted to CMS for approval.

#### FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs)

1. The state must assure access to FQHCs. If a managed care plan can demonstrate to the U.S. Department of Health and Human Services and the Rhode Island Department of Human Services that both adequate capacity and an appropriate range of services for vulnerable populations exists to serve the expected enrollment in a service area without contracting with FQHCs, the plan can be relieved of this requirement. If FQHCs implement their own managed care plan, other managed care plans in the same service area will not be required to contract with FQHCs.
2. The state shall enter into a stop loss arrangement with Neighborhood Health Plan of Rhode Island and such other health plans as designated by the state to assure the continued maintenance and growth of an integrated health care delivery system.

The basis of the arrangement shall be one involving shared-risk between the designated Plan(s) and the state relative to control of administrative expenses and medical expenses. The specifics of the arrangement, including designated performance objectives, are delineated in the health plan(s) contract addendum. The arrangement shall be in effect during the period of the waiver. All payments made to plan(s) under this stop-loss arrangement will be reflected in budget neutrality calculations. If, during this time, the state seeks to alter this arrangement, the state must submit the change for CMS's approval.

#### INSTITUTIONS FOR MENTAL DISEASES (IMDs)

1. IMD services provided under the demonstration shall be restricted to Butler Hospital, a short-term psychiatric hospital, subject to the following limitations:

<u>Period</u>	<u>Allowable Portion of Expenditures</u>
August 1, 2002 – July 31, 2003	100%
August 1, 2003 – July 31, 2004	50%
August 1, 2004 – July 31, 2005	0%

#### ELIGIBILITY

1. To reflect a policy of family responsibility, the state considers each member of the family unit (including any Medicaid eligible members) for purposes of determining countable income. Countable income therefore includes the income of the applicant as well as that of the following family members who reside in the household: 1) individuals for whom the applicant has financial responsibility; 2) individuals who have financial responsibility for the applicant; and 3) any other individual for whom such individual in (2) above has financial responsibility. Note: the income of a step-parent that has financial responsibility is also included when determining eligibility for an applicant child.

#### COST SHARING AND WAITING PERIOD PLAN

1. If the state makes any changes to the cost sharing or waiting period provisions of the demonstration, the state will need to submit updates to CMS 30 days in advance of implementing the changes plan (the original plan was submitted to CMS on July 10, 2002 in the form of a letter). However, if there are any changes to the actual parameters of the cost sharing and waiting periods that were approved in this amendment, the state will need to submit the plan to CMS for approval. In addition, if there are any changes to the population that is affected by the cost sharing and waiting periods, the state will need to submit the plan to CMS for approval.

#### PREGNANT UNDOCUMENTED ALIENS

1. Pregnant undocumented aliens will only be covered for emergency services under the current Title XIX program.

#### ENCOUNTER DATA REQUIREMENTS

1. The state shall require all providers to submit data as defined in the minimum data set submitted to CMS in project year one. The state must perform periodic reviews, including validation studies, in order to ensure compliance. A plan and schedule for validating encounter data shall be submitted to CMS for review. The validation plan must include a comparison of encounter data to an external data source, e.g., medical records. The state shall have provisions in its contracts with health plans to provide the data and be authorized

to impose financial penalties if accurate data are not submitted in a timely fashion. If the state fails to provide accurate and complete encounter data for any managed care plan, it will be responsible for providing to the designated CMS evaluator a statistically valid sample of data abstracted from medical records comparable to the data which would be available from encounter reporting requirements. The sampling methodology must be approved by CMS.

2. The state's plan for using encounter data to pursue health care quality improvement must, at a minimum, focus on the following priority areas:
  - o childhood immunizations;
  - o prenatal care and birth outcomes;
  - o pediatric asthma; and
  - o one additional clinical condition to be determined by the State based upon the population(s) served.

### QUALITY ASSURANCE REQUIREMENTS

1. The state must develop a methodology to monitor the performance of the health plans. At a minimum, the State shall monitor the quality assurance activities of each plan. The state will submit to the Center for Medicaid and State Operations (CMSO) and to the CMS Regional Office copies of all quality assessment reviews of these plans, including findings from all licensure inspections.

In addition, the state must contract with an external quality review organization (EQRO) for an independent audit each year of the demonstration. The state is to submit the RFP for the procurement of the EQRO to CMS for review.

2. The state shall establish a quality improvement process for bringing health plans that do not meet state program requirements up to an acceptable level.
3. The state shall collect and review quarterly reports on grievances received by each MCO, which describe the resolution of each formal grievance. Quarterly reports must also include an analysis of logs of complaints (which may be verbally reported to customer service personnel) as well as descriptions of how formal (written) grievances and appeals were handled.
4. A focused study of emergency room services, including inappropriate emergency room utilization by RIte Care enrollees, will be conducted by the state's EQRO contractor, and the results of the study shall be forwarded to CMS.

### Guidelines for State Monitoring of Plans

1. a. The state will require, by contract, that plans meet certain state-specified standards for Internal Quality Assurance Programs (QAPs) as required in 42 CFR 438.240.
  - b. The state will monitor, on a periodic or continuous basis (but no less often than every 12 months), plans' adherence to these standards, through the following mechanisms: review of each plan's written QAP; review of numerical data and/or

narrative reports describing clinical and related information on health services and outcomes; and on-site monitoring of the implementation of the QAP standards.

REQUIREMENTS FOR FEDERAL FINANCIAL PARTICIPATION/  
COST CONTROL/FISCAL ADMINISTRATION

1. a. The state will report net expenditures in the same manner as is done under the current Medicaid program. The state shall provide quarterly expenditure reports using the form CMS-64 to separately report expenditures for those receiving services under the Medicaid program, and RItE Care expenditures subject to budget neutrality. CMS will provide Federal Financial Participation (FFP) only for allowable RItE Care expenditures (as defined in 1.e below) that do not exceed the pre-defined limits specified in Attachment C.
- b. Rhode Island will report all Medicaid expenditures (including RItE Care expenditures subject to budget neutrality) through the MBES, following routine CMS-64 reporting instructions outlined in Section 2500 of the state Medicaid Manual. In this regard, RItE Care expenditures subject to budget neutrality will be differentiated from other Medicaid expenditures by identifying on forms CMS-64.9 and/or 64.9p the demonstration project number (including the project number extension) assigned by CMS. Because expenditures are reported on the CMS-64 by date of payment, Rhode Island must also submit along with each CMS-64 quarterly report supplemental schedules that detail services and reported waiver expenditures according to the waiver year in which the services were provided. For purposes of monitoring this waiver, cost settlements must be recorded on line 10.B. in lieu of lines 9 or 10.C.
- c. All claims for RItE Care services provided during the demonstration period (including any cost settlements) must be made within two years after the calendar quarter in which the state made the expenditures. During the period following the conclusion or termination of the demonstration, the state must continue to separately identify RItE Care waiver expenditures using the procedures addressed above.
- d. The term “RItE Care eligibles” shall include the following: (1) TANF and TANF-related women and children eligible for Medicaid under Rhode Island's existing state plan; (2) children who were made eligible for Medicaid under 1115 waiver authority who could be made eligible through a state Plan amendment under section 1902(r)(2) and related provisions; (3) parents who were made eligible for Medicaid under 1115 waiver authority who could be made eligible through a SPA under section 1931 and related provisions; and (4) women who lose Medicaid eligibility 60 days post partum and are eligible for extended family planning services under 1115 waiver authority.
- e. The term “RItE Care expenditures subject to budget neutrality” shall include the following: (1) RItE Care capitation payments; (2) all payments for extended family planning services for women who lose eligibility sixty days post partum; (3) supplemental payments made to prepaid health plans for costs associated with delivery (SOBRA “kick payments”); (4) supplemental payments to FQHCs; (5) reinsurance payments to health plans; (6) all fee-for-service claims for RItE Care eligibles (even when not enrolled in a prepaid health plan at the time the service was provided) with dates of service August 1, 1995 or later, including and limited to the services included in the base year per member/per month cost of \$103.30; and (7) window replacement costs (see Attachment C).

f. In addition to the form CMS-64, the state shall provide to CMS on a quarterly basis the number of eligible member/months for each category of RItE Care eligibles listed in 1.d above. Separate totals should be reported for each of the four categories listed. This information should be reported as part of the CMS-64 submission under the narrative section of the MBES. Reports for August 1, 1995 and beyond shall include eligible member/months for all RItE Care eligibles, regardless of their enrollment in a pre-paid plan.

2. The standard Medicaid funding process will be used during the RItE Care demonstration. Rhode Island must estimate matchable Medicaid and RItE Care expenditures on the quarterly Form CMS-37. CMS will make Federal funds available each quarter based upon the state's estimates, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing actual Medicaid and matchable RItE Care expenditures made in the quarter just ended. CMS will reconcile the allowable, actual expenditures reported on the Form CMS-64 with the Federal funding previously made available to the state for that quarter, and include the reconciling adjustment in a separate grant award to the state. The Forms CMS-37 and CMS-64 must clearly identify all categories of Medicaid and RItE Care expenditures, as outlined in 1.d above.
3. CMS will provide FFP at the applicable Federal matching rate for the following, subject to the limits described in Attachment C:
  - a. Administrative costs, including those associated with the administration of RItE Care.
  - b. Net expenditures and prior period adjustments of the Medicaid program, which are paid in accordance with the approved state plan. CMS will provide FFP for medical assistance payments with dates of service prior to and during the operation of the section 1115 waiver.
  - c. Net expenditures for services provided to RItE Care eligibles under 1115 waiver authority, including all types of expenditure listed in 1.e, less amounts that RItE Care eligibles are obligated to pay in premiums or co-payments.
4. The state will certify state/local monies used as matching funds for RItE Care purposes and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.

## Attachment B

### GENERAL ADMINISTRATIVE/REPORTING REQUIREMENTS

1. The state will submit quarterly progress reports, which are due 60 days after the end of each quarter (see below). The reports should include, as appropriate, a discussion of events occurring during the quarter that affect the following: health care delivery, the enrollment process for newly eligible people, enrollment and outreach activities, access; complaints and appeals to the state; the benefit package; quality of care; access; financial results; and other operational and policy issues. The report should also document utilization of health services based on encounter data by health plan. At a minimum, this should include physician visits, hospital admissions, and hospital days per 1,000 member months, broken out by pregnant women, other adults and children. The report should also include proposals for addressing any problems identified in the quarterly report. The information for the fourth quarterly report can be subsumed in the annual report. The annual report will document accomplishments, project status, including a budget update; quantitative and case study findings; and policy and administrative difficulties no later than 120 days after the end of its operational year. The state can consolidate the quarterly and annual reports for this waiver and the SCHIP waiver (# 21-W-00002/1-01).

#### Due Dates for Quarterly Reports and Annual Report

- Quarterly report for the quarter ending October 31 is due on December 31
  - Quarterly report for the quarter ending January 31 is due on March 31
  - Quarterly report for the quarter ending April 30 is due on June 30
  - Annual report for the operational year ending on July 31 is due on November 30 (this annual report will also serve as the fourth quarterly report)
2. Upon implementation of the waiting periods, the state will report on the number of people who are being denied eligibility to Rite Care for 6 months because they have either (1) had access to employer sponsored health insurance coverage for 6 months prior to application where the applicants share of the premium was no more than 50% of the premium or (2) had lost coverage in the past 6 months as a result of an employer who dropped coverage for a class of employees who would qualify for Medicaid. The state will provide this information broken out by eligibility group (e.g., children, parents, etc.). The state will also report on the actual premium cost that applicants incurred or would have to incur if they are being denied eligibility to Rite Care because of the first scenario described above. This information will be included in the quarterly reports.
  3. A draft final report should be submitted to the CMS project officer for comments. CMS's comments should be taken into consideration by the awardee for incorporation into the final report. The final report is due no later than 90 days after the termination of the project.

4. CMS may suspend or terminate any project in whole or in part at any time before the date of expiration, whenever it determines that the awardee has materially failed to comply with the terms of the project. CMS will promptly notify the awardee in writing of the determination and the reasons for the suspension or termination, together with the effective date. The state waives none of its rights to challenge CMS's finding that the state materially failed to comply. CMS reserves the right to withdraw waivers at any time if it determines that continuing the waivers would no longer be in the public interest. If a waiver is withdrawn, CMS will be liable for normal close-out costs.
5. The state shall provide any or all state-generated encounter data reports to CMS upon request.
6. The awardee shall assume responsibility for the accuracy and completeness of the information contained in all technical documents and reports submitted. The CMS project officer shall not direct the interpretation of the data used in preparing these documents and reports.
7. In order to track expenditures under this demonstration, Rhode Island must submit the following forms for RIte Care on a quarterly basis. Submit only one set of CMS-64s for the project.

CMS-64.9	CMS-64.9a
CMS-64.9p	CMS-64.9o
CMS-64.10	CMS-64 Certification
CMS-64.10p	CMS-64 Summary

Report all administrative and service expenditures allowed under the waivers approved for this demonstration. Do not include expenditures related to research and evaluation activities. These activities are funded separately.

8. During the last 6 months of the demonstration, no enrollment of individuals who would not be eligible under current law will be permitted.
9. Rhode Island will request modifications to the demonstration by submitting revisions to the original proposal for CMS approval. The state shall not submit amendments to the approved state plan relating to the new eligibles.
10. The state must continue to insure that an adequate MMIS is in place and provide evidence of such to CMS upon request. One feature of the system must be to report current enrollment by plan.
11. CMS will contract with an independent contractor to evaluate the demonstration. The state agrees to cooperate with the evaluator by responding in a timely manner to requests for interviews, access to records and sharing of data. The state has the right to review reports prepared by the evaluator.
12. Any letters, documents or other material sent to the project officer shall also be sent to the Boston Regional Office.

## Attachment C

### MONITORING BUDGET NEUTRALITY FOR THE RHODE ISLAND RITE CARE DEMONSTRATION

To ensure budget neutrality for the Rite Care Demonstration, a limit is placed on the amount of Federal financial participation (FFP) the state may receive during the demonstration period for the types of Medicaid expenditures described below. This limit is based on the estimated cost of serving the currently eligible population (as defined below) in the absence of a demonstration. The product of the cost estimate and the applicable Federal Medical Assistance Percentage (FMAP) will constitute the limit on the amount of FFP that the state may receive. The following section describes the method for calculating the expenditure limit.

For the purpose of calculating the expenditure limit, individuals who are eligible under the demonstration are divided into four Groups: (1) TANF and TANF-related women and children eligible for Medicaid under Rhode Island's existing state plan; (2) children who were made eligible for Medicaid under 1115 waiver authority who could be made eligible through a state Plan amendment under section 1902(r)(2) and related provisions; (3) parents who were made eligible for Medicaid under 1115 waiver authority who could be made eligible through a SPA under section 1931 and related provisions; and (4) women who lose Medicaid eligibility 60 days post partum and are eligible for extended family planning services under 1115 waiver authority. Rhode Island will be at risk for the per capita cost (as determined by the method described below) for current eligibles (as defined by Groups 1, 2 and 3 above), and for the extended family planning Group, but not at risk for the number of current eligibles. By providing Federal Financial Participation for all current eligibles, Rhode Island will not be at risk for changing economic conditions. However, by placing Rhode Island at risk for the per capita costs for current eligibles, CMS assures that the demonstration expenditures do not exceed the level of expenditures had there been no demonstration.

Should the state fail to supply complete FFS expenditure data, as required by Special Term and Condition (ST&C) #1.e of Attachment A, the state will be out of compliance of this special term and condition. In this instance, the state will be required to develop a corrective action plan within 30 days of award that provides a date for submitting the requested data. If the state fails to come into compliance according to this plan, CMS will pursue discontinuation of Rite Care, pursuant to ST&C #5 of Attachment B. Also, should CMS determine that Rite Care was not budget neutral during the initial five-year operational period, CMS may require the state to return the excess FFP to the extent Rite Care expenditures exceed the budget neutrality provisions, during the sixth or any subsequent year. The state, whenever it determines that the demonstration is not budget neutral or is informed by CMS that the demonstration is not budget neutral, shall immediately collaborate with CMS on corrective actions, which shall include submitting a corrective action plan to CMS within 21 days of the date the state has been informed of the problem. While CMS will aggressively pursue corrective actions with the state, CMS would work with the state to set reasonable goals in years 6, 7, and 8 that would ensure that the state is in compliance by year 8, and to reach consensus with the state on the amount the state is over the budget for the initial five-year operational period. As part of the corrective action plan the state will commit to repaying the over budget amount to CMS should the state become non compliant with the corrective action plan at any time. Repayment by the state would begin no earlier than year 6. If the state is not budget neutral by the end of the 8<sup>th</sup> year (regardless of

whether they were budget neutral during the first 5 years), the state will work with CMS to develop corrective action strategies that would make them budget neutral by the end of the 11<sup>th</sup> year.

Budget neutrality will be determined on an eleven year basis rather than on an annual basis. Any savings from budget neutrality may only be applied to an eligibility expansion or to offset demonstration costs in excess of the budget neutrality caps during this period. The state must submit for CMS approval a waiver amendment requesting the expansion. In its amendment, the state must demonstrate that the expansion is sustainable, even when the accrued savings from the initial five-year waiver period are exhausted.

#### Calculation of the Expenditure Limit

These are the steps involved in calculating the expenditure limit. For each year of the demonstration, the estimated cost of serving Medicaid eligibles in Groups (1), (2) and (3) will be calculated by multiplying the actual number of eligible months for these Groups (as reported by the state under Attachment A, 1.f) times the estimated per member/per month (PMPM) cost, which are given in the table below. By this method, a cost estimate is obtained for each year of the demonstration. At the end of the demonstration period, the Federal shares of the annual estimates will be calculated, using the FMAP rates applicable to each year. The sum of the annual Federal shares will be the limit on the amount of FFP that the state may receive during the demonstration period.

#### Estimated PMPM Cost

The base year for estimating PMPM costs in the absence of the demonstration will be SFY 1992. As reported by the state, the average cost of providing Medicaid services to Group (1) eligibles in SFY 1992 was \$103.30. Projected per member/per month cost for SFY 1993 and beyond are calculated by inflating the SFY 1992 PMPM cost, using the trend factors shown in the chart below. (The PMPM cost estimates for Group (2) have been reduced by 3% to account for the 3% of PMPM cost that is financed through member premiums or co-payments.) The base year for estimating PMPM costs in the absence of the demonstration for Group (3) is SFY 2001.

<b>SFY</b>	<b>Inflation factor</b>	<b>Group 1 PMPM cost</b>	<b>Group 2 PMPM cost</b>	<b>Group 3 PMPM cost</b>
1992 (base)		\$103.30	\$100.20	
1993	8%	\$111.56	\$108.21	
1994	6%	\$118.25	\$114.70	
1995	6%	\$125.35	\$121.59	
1996	4%	\$130.36	\$126.45	
1997	4%	\$135.57	\$131.50	
1998	4%	\$140.99	\$136.76	

1999	4%	\$146.63	\$142.23	
2000	4%	\$152.50	\$147.93	
2001(base Group 3)	4%	\$158.60	\$153.85	\$168.00
2002	6%	\$164.94	\$160.00	\$174.72
2003	6%	\$174.84	\$169.60	\$185.20
2004	6%	\$185.53	\$179.78	\$196.31
2005	6%	\$196.45	\$190.57	\$208.09

#### How the Limit Will Be Applied

The limit calculated above will apply to actual expenditures, as reported by the state under Attachment A, 1. If at the end of the demonstration period the budget neutrality limit has been exceeded, the excess Federal funds will be returned to CMS. No new limit is placed on FFP that the state may claim on expenditures for recipients and program categories not listed. If the demonstration is terminated prior to the 11-year period, the budget neutrality test will be based on the time period through the termination date.

## ATTACHMENT 2

### **Centers for Medicare & Medicaid Services – Special Terms and Conditions**

*<<< Project No. # 21-W-00002/1-01 >>>*

#### **I. PREFACE**

The following are Special Terms and Conditions for the award of the Rhode Island State Children's Health Insurance Program Section 1115 Demonstration (Rhode Island Demonstration) request submitted on January 10, 2001. The Special Terms and Conditions have been arranged into two broad subject areas: General Conditions for Approval and Program Design/Operational Plan. The demonstration populations are defined in the award letter that accompanies these Special Terms and Conditions.

In addition, specific requirements are attached and entitled: General Financial Requirements (Attachment A).

The State agrees that it will comply with all applicable Federal statutes relating to Nondiscrimination. These include, but are not limited to: the Americans with Disabilities Act, title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

Letters, documents, reports or other material that is submitted for review or approval shall be sent to the Rhode Island Demonstration Project Officer and the Associate Regional Administrator in the Boston Regional Office.

## II. GENERAL CONDITIONS

- A. CMS may suspend or terminate any project, in whole or in part, at any time before the date of expiration whenever it determines that the awardee has materially failed to comply with the terms of the project. CMS will promptly notify the awardee in writing of the determination and the reasons for the suspension or termination, together with the effective date. The State waives none of its rights to challenge CMS's finding that the State materially failed to comply. CMS reserves the right to withdraw waivers at any time if it determines that continuing the waivers would no longer be in the public interest. If a waiver is withdrawn, CMS will be liable for only normal closeout costs.
- B. The State may suspend or terminate this demonstration in whole or in part at any time before the date of expiration. The State will promptly notify CMS in writing of the reasons for the suspension or termination, together with the effective date. If the waiver is withdrawn, CMS will be liable for only normal close out costs.
- C. All requirements of the section 1115 demonstration No. 11-W-00004/1 entitled "RIte Care," and the Medicaid and SCHIP programs expressed in laws, regulations, and policy statements, not expressly waived or identified as not applicable in the award letter of which these Special Terms and Conditions are part, shall apply to the Rhode Island Demonstration.
- D. The State shall, within the time frame specified in law, come into compliance with any relevant changes in Federal law or regulations affecting the SCHIP program that occur after the demonstration award date. The State may submit to CMS a request for an amendment to the demonstration to request exemption from changes in law occurring after the demonstration award date.

### **III. PROGRAM DESIGN/OPERATIONAL PLAN**

#### **A. Concurrent Operation**

The State's title XIX State plan, as approved; its title XXI State plan, as approved; and its Medicaid section 1115 demonstration entitled "RIteCare," for the time period as approved; will continue to operate concurrently with this section 1115 demonstration.

#### **B. Maintenance of Coverage and Enrollment Standards for Children**

1. The State shall not close enrollment, institute waiting lists, or decrease eligibility standards with respect to the children covered under its title XXI State plan while the demonstration is in effect.
2. The State shall throughout the course of the demonstration continue to show that it has implemented procedures to enroll and retain eligible children for Medicaid. The State also shall throughout the course of the demonstration continue to show that it adopted and effectively implemented at least three of the following policies and procedures in its child health programs:
  - Use of a joint, mail-in application and common application procedures
  - Procedures that simplify the redetermination/coverage renewal process by allowing families to establish their child's continuing eligibility by mail
  - Elimination of assets test
  - Twelve-month continuous eligibility
  - Presumptive eligibility

The State may at any time submit to CMS a request for approval to change the particular policies or procedures used to meet this requirement.

3. In order to continue operation of the demonstration if the State exhausts the available title XXI Federal funds for the claiming period, the State will continue to provide coverage to its approved title XXI State plan population and the demonstration population with title XIX funds until further title XXI Federal funds become available. All Federal rules shall continue to apply during the period that title XXI Federal funds are not available.

#### **C. Enrollment Data Requirements**

The State will provide CMS with copies of the following enrollment reports quarterly:

- Actual and unduplicated enrollment of the demonstration populations by income, gender, race, and ethnicity. This enrollment information shall be provided to CMS in hard copy until such time as it can be reported through the SCHIP Statistical Enrollment Data System.
- Number of children whose eligibility for Medicaid or SCHIP Medicaid Expansion was up for recertification and number of adults whose eligibility for the demonstration was up for recertification.

- Number of children who were recertified to be eligible for Medicaid or SCHIP Medicaid Expansion and number of adults who were recertified to be eligible for the demonstration.
- Number of children who applied for Medicaid or SCHIP Medicaid Expansion and number of adults who applied for the demonstration but were denied for, at a minimum, the following reasons: income; failure to complete the application process; enrollment in other government programs; coverage by private insurance; or residence in another State.
- Number of children who were disenrolled from Medicaid or SCHIP Medicaid Expansion and number of adults who were disenrolled from the demonstration for, at a minimum, the following reasons: increase or decrease in income; failure to complete the renewal process; failure to pay premiums; enrollment in other government programs; purchase of private coverage; or residence in another State.

#### **D. General Reporting Requirements**

1. Through at least the first six months after implementation, CMS and the State will hold monthly calls to discuss progress.
2. The state will submit quarterly progress reports, which are due 60 days after the end of each quarter (see below). The state will submit quarterly progress reports, which are due 60 days after the end of each quarter (see below). The reports should include, as appropriate, a discussion of events relating to the demonstration populations that occurred during the quarter that affect the following: health care delivery; the enrollment process for newly eligible adults and pregnant women; enrollment and outreach activities; access; complaints and appeals to the State; the benefit package; and other operational and policy issues. The report should also include proposals for addressing any problems identified in the report. The information for the fourth quarterly report can be subsumed in the annual report. The annual report should include documentation of accomplishments; project status, including a budget update; quantitative and case study findings; policy and administrative difficulties; and progress on conducting the demonstration evaluation, including results of data collection and analysis of data to test the research hypotheses no later than 120 days after the end of its operational year. The state can consolidate the quarterly and annual reports for this waiver and the Medicaid waiver (# 11-W-00004/1).

#### Due Dates for Quarterly Reports and Annual Report

- Quarterly report for the quarter ending October 31 is due on December 31
- Quarterly report for the quarter ending January 31 is due on March 31
- Quarterly report for the quarter ending April 30 is due on June 30
- Annual report for the operational year ending on July 31 is due on November 30 (this annual report will also serve as the fourth quarterly report).

3. The State shall submit a continuation application by January 1 of each year (beginning in 2002). The continuation application must include an updated budget for the remainder of the demonstration period. In the continuation application, the State must demonstrate ongoing ability to fund title XXI coverage for the title XXI State plan population before using title XXI funding for demonstration populations, consistent with allotment neutrality as described in Attachment A.
4. At the end of the demonstration, a draft final report should be submitted to CMS for comments. CMS's comments must be taken into consideration by the State for incorporation into the final report. The State should use HCFA, Office of Research and Demonstrations' Author's Guidelines: Grants and Contracts Final Reports (copy attached) in the preparation of the final report. The final report is due no later than 90 days after the termination of the project.

## **ATTACHMENT A**

### **FINANCIAL REQUIREMENTS**

1. The State shall provide quarterly expenditure reports using the Form CMS-21 to report total expenditures for services provided under the approved SCHIP plan and those provided through the Rhode Island Demonstration under section 1115 authority. CMS will provide Federal Financial Participation (FFP) only for allowable Rhode Island Demonstration expenditures that do not exceed the State's individual allotment.
2.
  - a. In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid Budget and Expenditure System (MBES), as part of the routine quarterly CMS-21 reporting process. Title XXI demonstration expenditures will be reported on separate Form CMS-21, identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made).
  - b. All claims for expenditures related to the demonstration (including any cost settlements) must be made within two years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form CMS-21.
  - c. The standard SCHIP funding process will be used during the demonstration. Rhode Island must estimate matchable SCHIP expenditures on the quarterly Form CMS-21B. On a separate CMS 21B, the State shall provide updated estimates of expenditures for the waiver population. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-21 quarterly SCHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-21 with Federal funding previously made available to the State, and including the reconciling adjustment in the finalization of the grant award to the State.
  - d. The State will certify State/local monies used as matching funds for the demonstration and will further certify that such funds will not be used as matching funds for any other federal grant or contract, except as permitted by federal law.
3. Rhode Island will be subject to a limit on the amount of Federal title XXI funding that the State may receive on demonstration expenditures during the waiver period. Federal title XXI funding available for demonstration expenditures is limited to the State's available allotment, not including any redistributed funds. Should the State expend its available allotment, no further enhanced Federal matching funds will be available for costs of the demonstration populations until the next allotment becomes available. Title XIX federal matching funds will be provided if the title XXI allotment is exhausted.

4. If title XXI allocations are expended and the State chooses to draw down regular title XIX matching funds for *the demonstration populations* under 1115 waiver authority, the section 1115 budget neutrality cap specified in the Terms and Conditions for demonstration No. 11-W-00004/1 entitled "RItE Care" shall apply.
5. Total Federal title XXI funds for the State's SCHIP program (i.e., the approved title XXI State plan and the demonstration) are restricted to the State's available allotment and redistributed funds.
6. Total expenditures for outreach and other reasonable costs to administer the title XXI State plan and the demonstration that are applied against the State's title XXI allotment may not exceed ten percent of total expenditures.